STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145466	A. BUILDING _____ B. WING _____	04/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN LAKES REHAB & HEALTH CARE	310 EADS AVENUE PARIS, IL 61944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 677 SS=D	Annual Licensure and Certification Survey ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to assist a dependent resident (R282) with feeding and failed to provide therapy recommended separate food containers for a visually impaired resident (R282). R282 is one of one resident reviewed for activities of daily living on the sample list of 35. Findings include: R282's Discharge Transfer Orders dated 4/15/21 document R282's admission diagnosis of Acute CVA (cerebrovascular accident). The same Discharge Transfer Orders document the following: "Discharge Diet, Add extra moisturizer (butter, gravy, sauce etc.). 1:1 (one on one) supervision; standard aspiration precautions; assist with feeding; straws ok, single sips; meds (medication) one at a time; meds whole in puree; eliminate distraction; verbal cues for precautions; ensure pt (patient) alert for PO (by mouth). Liquid consistency: Thin. Diet Regular." R282's Hospital Inpatient Speech, Physical and Occupational Therapy, Discharge Recommendations dated 4/15/21 document the following: "Due to the visual impairment related to	F 677	1. For the Resident found to be affected by the alleged deficient practice (R282), the following corrective action has been taken to achieve compliance: A. The nursing and dietary staff was in-serviced regarding following and providing the recommended assistive eating devices. (Attachment A) B. The nursing and dietary staff was in-serviced to providing assistance at and between meals for dependent residents. (Attachment B) 2. All residents have the potential to be affected by the alleged deficient practice. However, due to the implementation of 1A-B, the alleged deficient practice will not recur. 3. The following systematic measures have been implemented to ensure that the alleged deficient practice does not recur: A. The Director of Nursing will randomly review at meal times those Residents that are dependent and require use of adaptive equipment. (Attachment C) 4. As part of the facilities ongoing quality assurance program: A. IDT reviews will be discussed during	5/10/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/14/2021

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F 677	Continued From page 1 (R282's) stroke, she now can only see in the left upper quadrant of her visual field. Between our therapy and nursing teams, we have implemented different strategies to help (R282) in safely navigating her environment and safely completing tasks. We (hospital inpatient therapy department) had a low vision occupational therapist specialist (unidentified) assess (R282) and make recommendations for adaptations and strategies. We have found the following strategies beneficial for (R282) and wanted to communicate them to her next level of care for continuity." On the second page of the same Discharge Recommendations under Vision: (tenth and eleventh bullet) document: "Use built-up handles on grooming and eating supplies to give texture and bold color. Use separate containers of separate colors for all meal items so that (R282) can differentiate items and find them easier." R282's Care Plan dated 4/15/21 documents the following: R282 has increased history of cognitive decline. "Problem/Need: Resident new to the facility, change in routine and normal habits indicates need for monitoring nutrition and hydration status. Goal: Resident will consume at least fifty percent of all food and fluids offered at meals to maintain adequate nutrition and hydration thru (through) admission review and care plan. Approach/Intervention: Check POS/Tray card for diet. Deliver tray and set up per resident preference. Assist with eating as necessary to complete task and maintain nutrition. Assist with between meal snacks and activities snacks as needed." On 4/21/21 at 10:25 am V9 (R282's family member) stated, "(R282) cannot see anything,	F 677	morning QA meeting and any concerns will be addressed with additional education and. or disciplinary action. B. Compliance will be monitored through the internal QA process.	

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F 677	Continued From page 2	F 677		

except a little light, out of either of her eyes since having a stroke about a month ago." V9 also stated Therapist (V5/Certified Occupational Therapist Assistant) is working with (R282) to find suitable activities that will work for (R282) and is assisting (R282) in adjusting to losing her vision. V9 also stated "(R282) is trying to adjust the best she can. She has had a lot of confusion since the stroke and already had some short term memory loss prior. (R282's) call light is attached to her chair. She can't remember where it is at and can't see it (call light). (R282) needs help with everything."

On 4/21/21 at 12:10 pm R282 was seated in R282's wheelchair, parked in the hallway corridor between two resident and staff filled dining/activity rooms. R282 had an 18 inch deep by 30 inch wide, empty bedside table parked in the front of R282's wheelchair.

On 4/21/21 at 12:20 pm V5 (Certified Nursing Assistant/CNA) delivered R282's lunch meal in a divided compartment styrofoam container, with plastic tableware, and a plastic glass of lemonade. The styrofoam container held turkey roast, mashed potatoes with gravy and carrots. V5 placed the container in the center of the bedside table. V5 slipped foam grip type devices onto the handles of R282's plastic fork and spoon. V5 told R282 that V5 put R282's spoon in R282's mashed potatoes and R282's fork in the turkey. V5 walked away and did not offer physical assistance. R282 leaned forward in the wheelchair to reach the bedside table. R282 tapped around on the bedside tray table until R282 found the styrofoam container and discovered the plastic spoon in the mashed potatoes. R282 raised the spoon full of mashed

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F 677	Continued From page 3	F 677		

potatoes towards R282's mouth, dropping some of the mashed potatoes into R282's lap. R282 then repeated the process after great difficulty, finding the styrofoam container and identifying the mashed potatoes by using R282's fingers. Mashed potatoes again dropped into R282's lap. R282 tried to get a third bite of food but was not able to find the styrofoam container. In scooping motions (R282) was dipping her spoon down directly on the table, missing the styrofoam container of food repeatedly. V7 (CNA) stopped in front of R282 and guided R282's spoon into the styrofoam container and walked away. R282 repeatedly attempted to feed herself with great difficulty. R282 was using her spoon on the table outside the container, putting an empty spoon to her mouth on several attempt. No other assistance was provided as R282 sat in the main hallway between the two dining rooms.

On 4/21/21 at 12:35 pm V2 (Director of Nursing/DON) acknowledged R282 was struggling to feed herself out of the styrofoam container with plastic tableware. V2 stated, "The newly admitted residents are in their rooms on isolation precautions and use styrofoam containers and plastic ware. (R282) was just taken off isolation precautions yesterday. Nobody told the kitchen (unidentified staff), so they didn't send (R282's) food on a plate with real silverware." V2 also stated, "We (facility staff) need to make sure (R282) gets physical assistance. I (V2, DON) can see she is having a hard time."

On 4/23/21 at 9:40 am V20 (Speech and Language Pathologist) stated V20 is in the facility this morning (4/23/21) evaluating R282. V20 also stated, "I (V20) think the hospital therapist

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F 677	Continued From page 4 recommendations that were sent here (to the facility) on (R282's) admission (4/15/21) are excellent and should have been implemented. They are a great starting point to guide the facility in the safety of (R282's) care, until I (V20) complete my own evaluation, and make my own recommendations. My (V20) recommendations will be implemented right away."	F 677		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to transcribe physician ordered medication, which resulted in repeated failures to follow a physician's order to administer a nonsteriodal anti-inflammatory pain/anti-platelet medication for R282. The facility failed to follow Physician orders to obtain a Physical Therapy Evaluation for R18. R18 and R282 are two of twelve residents reviewed for quality of care on the sample list of 35. Findings include: 1. R282's Physician Discharge Transfer Orders dated 4/15/21 document R282's admission diagnosis as: "Acute (severe and sudden onset)	F 684	1. For the Resident found to be affected by the alleged deficient practice (R282) (R18), the following corrective action has been taken to achieve compliance: A. The licensed nursing staff was in-serviced regarding Conformance with Physician Orders. (Attachment A) 2. All residents have the potential to be affected by the alleged deficient practice. However, due to the implementation of 1A, the alleged deficient practice will not recur. 3. The following systematic measures have been implemented to ensure that the alleged deficient practice does not recur: A. The Director of Nursing will review	5/10/21

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F 684	Continued From page 5 CVA (cerebrovascular accident)." The same Physician Discharge Transfer Orders include the following medication order: "Aspirin (over the counter nonsteriodal anti-inflammatory pain/anti-platelet medication), enteric coated, 81 mg (milligrams) tablet, delayed release. Dose: 81 mg, take one tablet by mouth every day. Start date 4/16/21." The same Physician Discharge Transfer Order documents a second antiplatelet medication (used to prevent platelet blood cells from clumping together) order: "Clopidogrel (prescription medication) 75 mg tablet, Dose: 75 mg. Take one tablet by mouth every day. Commonly known as Plavix." R282's Admission Physician Order Sheet (POS) dated 4/15/21 - 4/30/21 documents R282 was admitted to the facility on 4/15/21. The same POS does not document the physician ordered Aspirin medication. R282's Medication Administration Record (MAR) dated 4/15/21 - 4/30/21 does not have a transcribed physician order for Aspirin to be administered. On 4/21/21 at 4:45 pm V8 (Licensed Practical Nurse/LPN) reviewed the above POS and MAR and stated the following, "I missed the order for (R282's) Aspirin, when I wrote her (R282) admission orders (physician). I did not see the physician order for (R282's) Aspirin, so it is not on her MAR. (R282) has missed six (6) doses (Aspirin); she (R282) is supposed to be getting it (aspirin) to prevent another stroke (CVA)." On 4/21/21 at 4:55 am V2 (Director of Nursing/DON) stated, "(R282's) Aspirin order was not transcribed and had not been administered as	F 684	Daily New Order Log for compliance (Attachment B) 4. As part of the facilities ongoing quality assurance program: A. IDT reviews will be discussed during morning QA meeting and any concerns will be addressed with additional education and. or disciplinary action. B. Compliance will be monitored through the internal QA process.	

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F 684	Continued From page 6	F 684		

prescribed by the physician. I (V2, DON) will get that (aspirin) order (physician) on the MAR and make sure no other doses are missed (not administered)." V2 (DON) also stated, "I expect all physician orders to always be followed to the tee (to the letter)."

On 4/23/21 at 11:00 am V1 (Administrator/Registered Nurse/RN) provided a copy of R282's Medication Administration Record (MAR). R282's MAR had been updated as V2 (DON) stated above on 4/21/21. The updated MAR documents R282's Aspirin, Enteric Coated, 81 mg, one tablet by mouth daily, as it was ordered 4/15/21 on admission. The same MAR does not document R282 has received administration of the Aspirin, since V2 (DON) updated the POS and MAR. Two additional doses of Aspirin since 4/21/21 were not administered.

On 4/23/21 at 11:05 am V1 (Administrator/RN) stated the following, "(R282)'s Aspirin order was put on the MAR two days ago (4/21/21). There is no reason for (R282's) additional Aspirin doses (two) to be missed (not administered). I (V1) understand how the original order was not transcribed on (R282's) admission (4/15/21), resulting in the doses (six) being missed. This is a serious problem and another medication error. I (V1) will be addressing this immediately. I will call the doctor (V18/ Medical Director) and (R282's) POA (V9/Power of Attorney)."

On 4/23/21 at 2:30 pm V24 (Nurse Practitioner) stated, "As I documented in (R282's) Admission Progress Note (4/16/21), (R282) is ordered (physician) both prophylaxis (preventative) medications, Plavix (Clopidogrel) and Aspirin (medications). I (V24) absolutely expect the

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F 684	Continued From page 7	F 684		

nurses to give both to lower the risk of another CVA. (R282) has chronic a history of CVA and is currently stable. The Aspirin doses missed are not a significant medication error at this point, because (R282) has not missed any doses of the Plavix. There is always a risk of blood clots. The facility will resume the Aspirin and continue to monitor the resident(R282). At this time, I am not concerned; (R282) is stable."

2. R18's undated face sheet documents a diagnosis of Non Displaced Oblique Fracture of Right Tibia, Fracture of Lower End of Right Fibula, Cerebral Palsy and Difficulty in Walking.

R18's Cognitive Assessment dated 3/10/21 documents a score of 12 out of a total possible 15 points indicating moderate cognitive impairment.

X-Ray report of R18's right ankle dated 9/7/2020 documents impression "'Acute Non Displaced Distal Fibular Fracture."

R18's Physician Order Sheet (POS) dated September 1-30, 2020 documents a Physician order dated 9/3/2020 to have Physical Therapy (PT), Speech Therapy (ST) and Occupational Therapy (OT) to evaluate and treat R18.

V15 (Doctor of Podiatric Medicine/DPM) documented in 9/15/2020 progress note "Patient (R18) had a known ankle fracture at the start of September 2020. Patient was not placed in a boot. Patient was made partial weight bearing after knowing about her (R18) ankle fracture. Patient has pain with fracture."

On 4/22/21 at 2:50 PM V26 (Physical Therapy

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F 684	Continued From page 8 Assistant/PTA) stated R18 was never seen in therapy during the month of September 2020. V26 stated R18 had a start date of 11/10/20 for therapy received but no therapy was received from 7/20-11/20." On 4/23/21 at 9:00 AM V1 (Administrator) stated R18's order for PT/ST/OT to evaluate and treat dated 9/3/20 was never initiated.	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure one resident (R18) was safely transferred during toileting by staff not using a gait belt and R18 not wearing footwear during transfer. This failure resulted in R18 slipping in urine and sustaining a right ankle fracture. R18 is one of four residents reviewed for falls in a sample list of 35. Findings include: R18's undated face sheet documents a diagnosis of Non Displaced Oblique Fracture of Right Tibia, Fracture of Lower End of Right Fibula, Cerebral Palsy and Difficulty in Walking.	F 689	1. For the Resident found to be affected by the alleged deficient practice (R18), the following corrective action has been taken to achieve compliance: A. The nursing staff was in-serviced regarding Fall Prevention Policy. (Attachment A) 2. All residents have the potential to be affected by the alleged deficient practice. However, due to the implementation of 1A, the alleged deficient practice will not recur. 3. The following systematic measures have been implemented to ensure that the alleged deficient practice does not recur: A. The Director of Nursing will review at	5/10/21

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F 689	Continued From page 9 R18's Cognitive Assessment dated 3/10/21 documents a score of 12 out of a total possible 15 points indicating moderate cognitive impairment. R18's Investigation Report for Falls dated 9/2/20 documents R18 was barefoot during transfer and V27 (Certified Nurse Aide/CNA) did not use gait belt to transfer R18 from toilet to wheelchair. Quality Care Reporting Form dated 9/2/2020 documents R18 was being assisted off of toilet on 9/2/2020 at 4:45 AM. R18 stood barefooted with no gait belt in place, had urinary incontinence episode and slipped in urine. Staff was educated to have R18 wear proper footwear per this form. X-Ray report of R18's right ankle dated 9/7/2020 documents impression "'Acute Non Displaced Distal Fibular Fracture." V15 (Doctor of Podiatric Medicine/DPM) documented in 9/15/2020 progress note "Patient (R18) had a known ankle fracture at the start of September 2020. Patient was not placed in a boot. Patient was made partial weight bearing after knowing about her (R18) ankle fracture. Patient has pain with fracture." Final Incident Report to Illinois Department of Public Health documents the root cause of R18's acute Non Displaced Distal Fibular Fracture as "the facility feels the only incident that would have possibly caused the fracture was the fall on 9/2/2020." On 4/22/21 at 1:35 PM V13 (Licensed Practical Nurse/LPN) stated she remembers R18's fall on 9/2/20. V13 stated staff should have applied	F 689	least 3 transfers a week for compliance. (Attachment C) 4. As part of the facilities ongoing quality assurance program: A. IDT reviews will be discussed during morning QA meeting and any concerns will be addressed with additional education and. or disciplinary action. B. Compliance will be monitored through the internal QA process.	

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F 689	Continued From page 10 footwear such as no skid socks to R18's feet to help prevent fall. V13 stated staff should always use gait belt when transferring residents to prevent incidents and falls. "Using the gait belt and having resident wear shoes or no skid socks is for resident safety. This resident (R18) was not refusing anything that morning. At times she (R18) does refuse, but that morning she (R18) was being compliant." On 4/22/21 at 2:40 PM V2 (Director of Nurses/DON) stated R18 fell on 9/2/20 with no ankle injuries noted at that time. V2 stated V1 (Administrator) worked the floor on 9/7/20 and documented R18's right ankle was discolored. V2 stated an X-Ray was ordered and obtained which showed an acute right ankle fracture. V2 stated the staff should do everything possible to ensure resident safety including having resident wear footwear and staff should always use their gait belt. The facility policy titled 'Fall Prevention' revised 11/12/18 documents the following: "Policy: To provide for resident safety and minimize injuries related to falls. Procedure: All staff must observe residents for safety."	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690		5/10/21

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F 690	Continued From page 11 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure services were provided to identify and/or treat a possible Urinary Tract Infection in one (R31) of one resident reviewed for Urinary Catheters and Urinary Tract Infections in the sample list of 35. Findings include: R31's Physician Order Sheet dated April 2021 includes the following diagnoses: Congestive	F 690	1. For the Resident found to be affected by the alleged deficient practice (R31), the following corrective action has been taken to achieve compliance: A. The licensed nursing staff was in-serviced regarding Notification for Change in Resident Condition or status. (Attachment A) B. The nursing staff was in-serviced regarding General Rules of Charting/Documentation. (Attachment B)	

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	145466	A. BUILDING _____ B. WING _____	04/23/2021

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F 690	Continued From page 12 Heart Failure, Coronary Artery Disease, Hypertension and Pressure Ulcers. R31's Minimum Data Set (MDS) dated 3/30/21 documents R31 as frequently incontinent of Bladder and Bowel. This same MDS documents R31 needing the assistance of two staff for activities of daily living. R13's Nursing Note dated 4/15/21 (6pm - 6am) documents the following entry: "CNA's (Certified Nursing Assistants) came to this nurse (V21/Registered Nurse) to report a (incontinence brief) full of green urine. This nurse (V21) went to (R31's) room. The (incontinence brief) was full of light to medium copious amounts of green mucus with foul odor. Will inform day nurse (V12/Licensed Practical Nurse)." R13's Nursing Note dated 4/16/21 at (6:20 am) documents "Report of above given to (V12)." On 4/20/21 R31's Medical Record contained no further information or entries regarding the abnormal urine (as described above) by V21 and reported to V12. On 4/20/21 at 1:15 pm, V24 (Family Nurse Practitioner) confirmed V24 had no knowledge of R31's abnormal urine findings and there had been no messages left on V24's or V18's (Primary Care Physician) phone service about R31's abnormal urine over the previous weekend. V24 stated "This should have been reported. (V31) will need to have a UA (Urinalysis) completed and some blood work." On 4/20/21 at 1:40 pm, V2 (Director of Nursing) confirmed the entry in R31's Nursing Notes. V2	F 690	2. All residents have the potential to be affected by the alleged deficient practice. However, due to the implementation of 1A-B the alleged deficient practice will not recur. 3. The following systematic measures have been implemented to ensure that the alleged deficient practice does not recur: A. The Director of Nursing will review Daily New Order /Condition Log for appropriate notification/documentation and follow up. (Attachment C) 4. As part of the facilities ongoing quality assurance program: A. IDT reviews will be discussed during morning QA meeting and any concerns will be addressed with additional education and. or disciplinary action. B. Compliance will be monitored through the internal QA process.	

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F 690	Continued From page 13 stated V2 knew nothing about the abnormal urine observation. V2 also stated it should have been reported to V24 or to V18. V2 confirmed there should have been follow up Nursing Notes in R31's chart. V2 stated V12 should have reported this immediately and documented that it had been reported, along with any orders. On 4/20/21 at 2:00 pm V2 confirmed V2 had spoken to V12 and V12 acknowledged the abnormal urine on R31's incontinent brief had been reported to V12 by V21, but V12 had not reported it to V24 or V18. On 4/20/21, V24 wrote an order for a UA (Urinalysis), Complete Metabolic Profile (CMP) and Complete Blood Count (CBC) to be done on R31. A Laboratory Report dated 4/22/21 documents R31's results on a urinalysis as follows: Protein 70 mg/dl (milligrams per deciliter) normal range is below 20, Leukocytes 500 Leu/ul (leukocyte esterase in urine large amount), normal is less than 25, UR Blood (urine blood) 0.2 mg/dl average range is less than 0.03, UR WBC (urine white blood cells) 100 plus /hpF (high power field) normal is less than 5, UR RBC (urine red blood cells) 11-25, normal is less than 2, Squamous Epithelial 100 plus, normal is less than 2. A Laboratory Report dated 4/23/21 for R31 documents a preliminary culture of R31's urine as positive for Gram Negative Rods. Specific organism to be determined on final results.	F 690		
F 842 SS=D	Resident Records - Identifiable Information	F 842		5/10/21

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F 842	Continued From page 14 CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert	F 842		

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F 842	Continued From page 15 a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a resident's (R31) Medical Record was accurate and complete after an invasive procedure was performed. R31 is one of 22 residents reviewed for Medical Record Accuracy and Completeness in the sample list of 35. Findings include:	F 842	For the Resident found to be affected by the alleged deficient practice (R31), the following corrective action has been taken to achieve compliance: A. The nursing staff was in-serviced regarding General Rules of Charting/Documentation. (Attachment A) 2. All residents have the potential to be affected by the alleged deficient practice. However, due to the implementation of	

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F 842	Continued From page 16 R31's Physician Order Sheet dated April 2021 includes the following diagnoses: Congestive Heart Failure, Coronary Artery Disease, Hypertension and Pressure Ulcers. R31's Minimum Data Set (MDS) dated 3/30/21 documents that R31 is frequently incontinent of Bowel and Bladder. R13's Nursing Note dated 4/15/21 (6pm - 6am) documents the following entry: "CNA's (Certified Nursing Assistants) came to this nurse (V21/Registered Nurse)) to report a (incontinence brief) full of green urine. This nurse (V21) went to (R31's) room. The (incontinence brief) is full of light to medium copious amounts of green mucus with foul odor. Will inform day nurse (V12/Licensed Practical Nurse)." R13's Nursing Note dated 4/16/21 (6:20 am) documents "Report of above given to (V12)." There is no further documentation in R31's Medical Record on this abnormal finding. On 4/20/21, V24 (Nurse Practitioner) wrote an order for a Urinalysis (UA), Complete Metabolic Profile (CMP) and Complete Blood Count (CBC) to be done. On 4/22/21 at 10:30 am, R31's Medical Record contained no entries on the collection of urine for a Urinalysis per V24's 4/20/21 order. On 4/22/21 at 10:45 am V2 (Director of Nursing) stated the night nurse (unidentified) on 4/20/21 had tried several times to obtain a urine from R31 via a straight catheterization but was not able to complete the procedure. V2 stated, "I stayed late yesterday (4/21/21) and did the catheterization	F 842	1A, the alleged deficient practice will not recur. 3. The following systematic measures have been implemented to ensure that the alleged deficient practice does not recur: A. The Director of Nursing will review new order log for appropriate documentation. (Attachment B) 4. As part of the facilities ongoing quality assurance program: A. IDT reviews will be discussed during morning QA meeting and any concerns will be addressed with additional education and. or disciplinary action. B. Compliance will be monitored through the internal QA process.	

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F 842	Continued From page 17	F 842		

myself and (R31's) urine was sent to the laboratory this morning." V2 confirmed that neither V2 or the (unidentified) night nurse had documented in R31's chart that this invasive procedure had been done and a urine sample had been sent. V2 also confirmed that this procedure should have been documented in the chart.

On 4/23/21 R31's Nursing Notes still did not have documentation that a urine sample had been collected via straight catheterization or sent to the laboratory for analysis.

A facility Policy undated and titled as follows documents:

"Nursing Documentation Guidelines:

1. Every shift documentation is required for problem areas for a minimum of 24 hours or until symptoms have resolved.
A. Any time physician is called
B. Vomiting
C. Skin problems
D. Temperatures
E. Bleeding from any orifice
2. Three (3) day documentation on every shift is required on all new admissions/re-admissions.
3. Lab/x-ray abnormalities. Note regarding MD notification.
4. Refusal or holding of treatments or medications. MD should be notified after one missed treatment or one missed meds.
5. Be aware of facility policies and procedures on the following:
A. Draining wounds
B. Bloody stools
C. Falls, etc.

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F 842	Continued From page 18 D. Physician Notification 7. Vital signs A. Always be prepared to give the physician vital signs when you call her/him. B. Vital Signs are to be done every shift for the first three (3) days for a new admission/re-admission.. 8. Don't wait until physician's next visit to relate problems. 9. Objective rather than subjective documentation. Catheter Insertion and Care Documentation: 1. The type of procedure performed and who performed it. 2. The date and time the procedure was performed. 3. The type and size of the catheter used. 4. The necessity of the catheter. 5. Resident's response to the treatment. 6. Changes in the resident's condition (i.e., swelling, discomfort, change in output, amount, color, odor, any sediment, patency of the catheter, etc.). 7. Amount of urine output. If specimen sent to the laboratory and the reason. 8. Any special care, as well as any new problems that may have developed. 9. Other pertinent data as necessary. 10. Date, time, signature, and title of the person recording the data."	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880		5/10/21

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F 880	Continued From page 19 designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the	F 880		

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F 880	Continued From page 20 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to prevent cross contamination during meal service to one (R7) resident and while providing services to one (R232) resident out of two residents reviewed for infection control in a sample list of 35. Findings include: 1. R232's undated face sheet documents R232 admitted to facility on 4/12/21 with a diagnosis of Pneumonia. R232's Care Plan does not include a focus area, goal nor any interventions regarding R232 being	F 880	1. For the resident identified to be potentially affected by the alleged deficient practice, corrective actions have been achieved by the following: A. All staff was immediately in-serviced on Infection Control Surveillance and Monitoring including PPE related to droplet precautions and COVID 19 Control Measures. (Attachment A) B. All staff received follow up in-service in Infection Control Surveillance and Monitoring and COVID 19 Control Measures. (Attachment B) C. All staff received education of the	

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F 880	Continued From page 21 placed on quarantine due to being admitted within 14 days. On 4/21/21 at 10:30 AM, R232's room door had droplet precaution and contact precaution signs posted on outside of door. Isolation cart with gloves, disposable bags and disinfectant wipes on top of cart sat outside R232's room in hallway. R232 was sitting in upright chair with bedside table in front of R232. V25 (Business Office Manager/BOM) was kneeling beside R232 without gown, gloves or eye protection on completing business office paperwork. V25 and R232 were handing same pen back and forth to each other without sanitizing pen. V25 did not wear eye protection, gown or gloves. V25 (BOM) and R232 were within two feet of each other for an extended period of time. On 4/21/21 at 10:55 AM V25 (BOM) stated R232 is currently on quarantine due to being a new admission. V25 stated she should have worn appropriate Personal Protective Equipment (PPE) while assisting a resident on quarantine. V25 stated not wearing appropriate PPE of a gown, gloves and eye protection could cause illness for other residents or staff. 2. On 4/21/21 at 12:45 PM V22 (Certified Nurse Aide/CNA) removed a contaminated breakfast tray from R7's room with ungloved hands and placed it on the top shelf of the lunch tray cart that contained numerous meals ready to be served to residents eating in their rooms for lunch. V22 did not wash hands or use Alcohol Based Hand Rub (ABHR) after touching R7's contaminated breakfast tray and handling other resident meal trays. R7's contaminated breakfast tray had paper garbage and styrofoam containers	F 880	following : Sparkling Surfaces – https://youtu.be/t7OH8ORr51g Clean Hands – https://youtu.be/xmYMUly7qiE Lessons – https://youtu.be/YYTATw9yav4 (Attachment C) D. The Director of Nurses completed CDC's Infection Preventionist training in CDC – Train (Attachment D) E. A Root Cause Analysis's was conducted by the Quality Assurance Team and determined the elements leading to noncompliance cited at F880. (Attachment E) 2. All residents have the potential to be affected by the alleged deficient practice; however no resident will be affected due to the implementation of 1 A-E. 3. The following Quality Assurance Plan has been implemented to ensure the alleged deficient practice does not recur. A. The nurse on each shift will document all resident and staff infections on the facility's infection tracking log. B. The Infection Preventionist will review the infection control log on the next business day and report any increase infections to the Medical Director and Illinois Department of Public Health. C. The facility will ensure adequate supply of PPE is readily available to all staff. D. The Infection Preventionist will conduct rounds throughout the facility to ensure staff is using appropriate personal protective equipment and to ensure infection control procedures are followed.	

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F 880	Continued From page 22 that had partially eaten food in them. On 4/21/21 at 12:50 PM V22 (CNA) stated resident meal trays that residents have eaten off of and been in resident rooms should be placed underneath any resident meal trays that have not been served yet. V22 stated placing the contaminated tray on top would cause the other trays to be contaminated. V22 stated "I did use hand sanitizer most of the time, I just forgot a few times." V22 stated hand sanitizer helps reduce the risk of cross contamination. The facility policy titled 'Handwashing' reviewed 12/7/18 documents the following: "All staff will wash hands, as washing hands as promptly and thoroughly as possible after resident contact and after contact with blood, body fluid, secretions, excretions and equipment or articles contaminated by them is an important component of the infection control and isolation precautions."	F 880	Immediate education will be provided to persons not correctly utilizing infection control practices. E. The results of the rounds will be reviewed during weekly and quarterly Quality Assurance and Performance Improvement meetings.	
F 912 SS=C	Bedrooms Measure at Least 80 Sq Ft/Resident CFR(s): 483.90(e)(1)(ii) §483.90(e)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide bedrooms that measure at least 80 square feet per resident bed. This failure affects 35 of 35 residents all of whom occupy Medicare or Medicaid certified beds in the facility. Findings include:	F 912	1. The facility respectfully requests a waiver for this standard (room size) 2. The corrective actions taken for the rooms indicate rooms: 2, 4 through 11 and 14-32. 3. The facility does assure that all rooms have adequate space to assure quality resident care and comfort. It is important to note that the special needs of each	5/10/21

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TWIN LAKES REHAB & HEALTH CARE	310 EADS AVENUE PARIS, IL 61944

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F 912	Continued From page 23 Historical room documentation and actual onsite measurements determine rooms 2, 4 through 11, and 14 through 32 are undersized, providing only 77.3 square feet per resident bed. The most recent Centers for Medicare and Medicaid Services Certification and Transmittal dated 9/11/20 documents 56 of the facility's 62 beds are certified Title 18 (Medicare) and/or Title 19 (Medicaid). Rooms 2, and 4 through 11 are double occupancy and dually certified for Medicare and Medicaid, while rooms 14 through 32 are double occupancy and certified for Medicaid. The facility's Daily Roster dated 4/18/21 documents 35 of these 56 certified beds are occupied by residents residing in the facility. On 4/23/21 at 1:00 PM V1 (Administrator) stated, "We have undersized rooms, we go through this every year."	F 912	resident are addressed and none of the rooms identified adversely affect the residents health or safety. The rooms contain all of the required furnishings. Space for resident personal possessions, medical equipment and appliances are provided. There have been no complaints or grievances from residents or legal representatives regarding room size. 4. We have received no complaints related to room size. If complaints are received in the future, they will be addressed immediately. If any problem arises at a future time, that problem will be addressed individually to meet the resident's needs. 5. The Administrator/Designee will continue to monitor for compliance.	